

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 3, 4, 5, and 7, 2011</p> <p>Facility number: 000989 Provider number: 15G475 AIM number: 100244900</p> <p>Surveyors: Tim Shebel, Medical Surveyor III-Team Leader Christine Colon, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/20/11 by Chris Greeney, Medical Surveyor Supervisor and Ruth Shackelford, Medical Surveyor III.</p>			W0000			
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview, the governing body failed for 4 of 5 clients (clients #1, #2, #3 and #4)</p>			W0104	<p>Clients #1, 2, 3, & 4 will be reimbursed for haircut and hygiene products purchased. To ensure future compliance,</p>		11/07/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>living at the group home, to exercise general operating direction in a manner 1. To ensure clients did not pay for hair cuts and hygiene products and 2. To provide oversight to ensure their "Policy for Handling Cases of Neglect and Abuse" was implemented.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted at the facility's administrative office on 10/4/11 at 11:50 A.M.. A financial record review for clients #1, #2, #3 and #4 was completed. The financial review indicated client #1 had paid for a hair cut on 1/6/11 in the amount of \$10.00. The record also indicated: "Receipt dated 12/20/10...body wash \$7.49." The financial record review indicated client #2 paid for a haircut on 1/6/11 in the amount of \$10.00. The record also indicated: "Receipt dated 12/20/10...body wash \$3.47, body wash \$3.47, body wash \$3.47, bath soap \$3.76." The financial record review indicated client #3 paid for a hair cut on 1/6/11 in the amount of \$10.00. The financial record review indicated client #4 paid for a hair cut on 1/6/11 in the amount of \$10.00. Further review of client #1, #2, #3 and #4's records did not indicate they were reimbursed for the mentioned expenses.</p>				<p>Service Coordinator will audit their budgets twice monthly. Service Coordinator will re-train the DSP to call for permission to withdraw any money from Clients accounts. To ensure future compliance, Service Coordinator will audit client's bank accounts monthly for three months, and budgets will be audited twice monthly. The missing money for client's #1, 2, 3, & 4 were reimbursed October 7, 2011. All of the DSPs in the group home have been trained to call the Service Coordinator for permission to take the clients to the bank to withdraw any money from their accounts. To ensure future compliance, Service Coordinator will monitor with the following protective measures: Clients must be present during any banking activity on their accounts. Service Coordinator will compare the budgets, bank withdraws and deposits slips to the bank activity/statements monthly.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>An interview with the Service Coordinator (SC) was conducted on 10/4/11 at 12:20 P.M.. The SC indicated clients #1, #2, #3 and #4 had not been reimbursed for the mentioned expenses.</p> <p>2. A review of the facility's records was conducted on 10/4/11 at 10:40 A.M.. Review of the facility's investigation record indicated internal incident/accident reports and Bureau of Developmental Disabilities Services (BDDS) reports which indicated the following:</p> <p>A. Incident/Accident report dated 4/11/11 and 4/9/11, date of referral 6/30/11: "Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>B. Incident/Accident report dated 4/11/11 and 3/23/11: "Someone has made withdrawal out of [client #2]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>the report failed to indicate the amount of money withdrawn.</p> <p>C. Incident/Accident report dated 4/11/11 and 5/23/11: "Someone has made withdrawals out of [client #3]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>D. Incident/Accident report dated 4/11/11: "Someone has made withdrawals out of [client #4]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>E. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #1) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>F. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #2) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>G. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #3) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>H. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>#4) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>Further review of the investigation record indicated:</p> <p>1. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15539...[Client #4]...Date: 6/30/11...Someone has made withdrawals out of [client #4] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>2. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15538...[Client #1]...Date: 6/30/11...Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>3. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15540...[Client #3]...Date:</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>6/30/11...Someone has made withdrawals out of his account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15541...[Client #2]...Date: 6/30/11...Someone has made withdrawals out of [client #2] savings account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>Review of the SC notes dated 7/17/11 indicated: "No deposit slips for 4/11/11 or 5/23/11 for all gentleman...Budgets were available-(not done)."</p> <p>A review of the clients' personal financial records dated 6/24/11 to 9/30/11 was conducted on 10/4/11 at 11:50 A.M.. Review of client #1's record failed to indicated a cash reimbursement from the facility for missing funds. Review of client #2's record failed to indicate a cash reimbursement from the facility for missing funds. Review of client #3's record failed to indicate a cash reimbursement from the facility for missing funds. Review of client #4's record failed to indicate a cash reimbursement from the facility for missing funds.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>A review of the facility's "Policy for Handling Cases of Neglect and Abuse" dated 12/20/08 was conducted on 10/4/11 at 12:50 P.M. and indicated: "In order to protect the general welfare of the clients, [Facility name] has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staff... [Facility name] prohibits all abuse, neglect and exploitation of our clients...Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure...All allegations of abuse, neglect, humiliation or exploitation will be investigated...Exploitation-is defined as the unauthorized use or misuse of a client's labor, funds, property or other assets for one's own profit or advantage. Examples include but are not limited to using their finances without permission...The designated staff conducting the investigation will submit to the Quality Assurance Specialist or designee...as soon as possible (preferably within 24 hours) a written summary of any and all information gathered with regard to the incident...Upon receipt of the final report, the Quality Assurance Specialist or designee will complete the necessary follow-up report within 5 days (and thereafter as needed)."</p> <p>An interview with the Service</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0140	Coordinator (SC) was conducted on 10/4/11 at 12:20 P.M.. The SC indicated the reporting staff reported the incidents to her but she had to wait for the bank statements to come to verify the withdrawals. The SC indicated the investigation was still open and the clients would be reimbursed for the missing funds this week. The SC further indicated no follow up reports were submitted.						
	9-3-1(a)						
	The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed to maintain an accurate accounting system for 4 of 5 clients living at the group home (clients #1, #2, #3 and #4), for whom the facility managed their personal funds accounts.						
	Findings include:						
	A review of the facility's records was						
				W0140	See tag # 104, p. 2 Please tag 104		11/07/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>conducted on 10/4/11 at 10:40 A.M.. Review of the facility's investigation record indicated internal incident/accident reports and Bureau of Developmental Disabilities Services (BDDS) reports which indicated the following:</p> <p>A. Incident/Accident report dated 4/9/11 and 4/11/11, date of referral 6/30/11: "Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>B. Incident/Accident report dated 4/11/11 and 3/23/11: "Someone has made withdrawal out of [client #2]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>C. Incident/Accident report dated 4/11/11 and 5/23/11: "Someone has made withdrawals out of [client #3]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>separation of duties." Further review of the report failed to indicate the amount of money withdrawn..</p> <p>D. Incident/Accident report dated 4/11/11: "Someone has made withdrawals out of [client #4]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>E. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #1) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>F. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #2) that there seemed to be money missing from his account...Service Coordinator started gathering information</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>G. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #3) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>H. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #4) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>requested formal internal investigation."</p> <p>Further review of the investigation record indicated:</p> <p>1. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15539...[Client #4]...Date: 6/30/11...Someone has made withdrawals out of [client #4] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>2. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15538...[Client #1]...Date: 6/30/11...Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>3. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15540...[Client #3]...Date: 6/30/11...Someone has made withdrawals out of his account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15541...[Client #2]...Date: 6/30/11...Someone has made withdrawals</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>out of [client #2] savings account."</p> <p>Further review of the report failed to indicate the amount of money withdrawn.</p> <p>Review of the SC notes dated 7/17/11 indicated: "No deposit slips for 4/11/11 or 5/23/11 for all gentleman...Budgets were available-(not done)...\$35.00 x 3 missing and \$50.00 x 4 missing." Further review failed to indicate what amount belonged to each client.</p> <p>A review of the clients' personal financial records dated 6/24/11 to 9/30/11 was conducted on 10/4/11 at 11:50 A.M.. Review of client #1's record failed to indicate the mentioned withdrawals or a cash reimbursement from the facility for missing funds. Review of client #2's record failed to indicate the mentioned withdrawals or a cash reimbursement from the facility for missing funds. Review of client #3's record failed to indicate the mentioned withdrawals or a cash reimbursement from the facility for missing funds. Review of client #4's record failed to indicate the mentioned withdrawals or a cash reimbursement from the facility for missing funds.</p> <p>An interview with the Service Coordinator (SC) was conducted on 10/4/11 at 12:40 P.M.. The SC indicated the clients' financial records should reflect</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0149	<p>when money is withdrawn for purchases and when funds are deposited into each clients' personal petty cash funds. The SC further indicated the withdrawals were not reflective on each clients personal financial records.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility neglected to implement their abuse/neglect policy to immediately report, to the facility's administrator: 1. 1 of 3 injuries of unknown origin which involved 1 of 2 sampled clients living at the group home (client #1 and 2.) for 4 of 5 clients residing at the group home (clients #1, #2, #3 and #4), the facility neglected to implement its "Policy For Handling Cases of Neglect and Abuse" by not ensuring staff did not financially exploit the clients.</p> <p>Findings include:</p> <p>1. The facility's incident reports,</p>		W0149	<p>Service Coordinator will train DSP's on proper reporting procedures. To ensure future compliance, Service Coordinator will review incidents reports when received.</p> <p>The missing money for client's #1, 2, 3, & 4 were reimbursed October 7, 2011.</p>		11/07/2011	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>abuse/neglect allegations, and investigations, from 10/1/10 to 10/3/11, were reviewed on 10/3/11 at 2:06 P.M.. The review indicated the following injury of unknown origin involving client #1: "Name: [Client #1], Incident Date: 05/27/2011, Date of knowledge: 05/31/2011, Narrative: While assisting [client #1] with a bath, staff noticed a bruise on [client #1's] left hip. Staff asked [client #1] how he got the bruise and he (client #1) stated that he did not know. Plan to Resolve: Staff filled out a (sic) incident report and sent it in the mail to the Community Services Nurse (Nurse #3.) Due to the holiday weekend and the fact that the staff is new, we (Service Coordinator #1 and Nurse #3) did not receive the report until 5/21/11. An internal investigation has been started to determine the origin of the bruise, will follow up with the results upon completion."</p> <p>Service Coordinator #1 was interviewed on 10/4/11 at 11:52 A.M.. Service Coordinator #1 indicated the bruise to client #1's hip was discovered by staff on 5/27/11 and the facility's administrator was not notified of the injury to client #1 until 5/31/11.</p> <p>The facility's records were further reviewed on 10/4/11 at 2:52 P.M..</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Review of the facility's "Policy for Handling Cases of Neglect and Abuse", dated 12/20/2006, indicated, in part, the following: "The staff person(s) observing or who has become aware of the incident must immediately: . . . c. verbally inform his/her immediate supervisor of the suspected incident."</p> <p>2. A review of the facility's records was conducted on 10/4/11 at 10:40 A.M.. Review of the facility's investigation record indicated internal incident/accident reports and Bureau of Developmental Disabilities Services (BDDS) reports which indicated the following:</p> <p>A. Incident/Accident report dated 4/9/11 and 4/11/11, date of referral 6/30/11: "Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>B. Incident/Accident report dated 4/11/11 and 3/23/11: "Someone has made withdrawal out of [client #2]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>C. Incident/Accident report dated 4/11/11 and 5/23/11: "Someone has made withdrawals out of [client #3]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>D. Incident/Accident report dated 4/11/11: "Someone has made withdrawals out of [client #4]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>E. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #1) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home;</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>F. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #2) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>G. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #3) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>H. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>she went to the bank with a client (client #4) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>Further review of the investigation record indicated:</p> <p>1. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15539...[Client #4]...Date: 6/30/11...Someone has made withdrawals out of [client #4] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>2. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15538...[Client #1]...Date: 6/30/11...Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>3. Staff/Client Incident Report Summary Sheet: "Incident Report Number:</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>15540...[Client #3]...Date: 6/30/11...Someone has made withdrawals out of his account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15541...[Client #2]...Date: 6/30/11...Someone has made withdrawals out of [client #2] savings account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>Review of the SC notes dated 7/17/11 indicated: "No deposit slips for 4/11/11 or 5/23/11 for all gentleman...Budgets were available-(not done)...\$35.00 x 3 missing and \$50.00 x 4 missing." Further review failed to indicate what amount belonged to each client.</p> <p>A review of the clients' personal financial records dated 6/24/11 to 9/30/11 was conducted on 10/4/11 at 11:50 A.M.. Review of client #1's record failed to indicated a cash reimbursement from the facility for missing funds. Review of client #2's record failed to indicate a cash reimbursement from the facility for missing funds. Review of client #3's record failed to indicate a cash reimbursement from the facility for missing funds. Review of client #4's</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>record failed to indicate a cash reimbursement from the facility for missing funds.</p> <p>A review of the facility's "Policy for Handling Cases of Neglect and Abuse" dated 12/20/08 was conducted on 10/4/11 at 12:50 P.M. and indicated: "In order to protect the general welfare of the clients, [Facility name] has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staff... [Facility name] prohibits all abuse, neglect and exploitation of our clients...Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure...All allegations of abuse, neglect, humiliation or exploitation will be investigated...Exploitation-is defined as the unauthorized use or misuse of a client's labor, funds, property or other assets for one's own profit or advantage. Examples include but are not limited to using their finances without permission...The designated staff conducting the investigation will submit to the Quality Assurance Specialist or designee...as soon as possible (preferably within 24 hours) a written summary of any and all information gathered with regard to the incident...Upon receipt of the final report, the Quality Assurance Specialist or designee will complete the</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0153	<p>necessary follow-up report within 5 days (and thereafter as needed)."</p> <p>An interview with the Service Coordinator (SC) was conducted on 10/4/11 at 12:20 P.M.. The SC indicated the reporting staff reported the incidents to her on 6/30/11 but she had to wait for the bank statements to come to verify the withdrawals. The SC indicated the investigation was still open and as of 10/4/11 the clients had not been reimbursed for the missing money. The SC further indicated no follow up reports were submitted.</p> <p>9-3-2(a)</p>						
	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed to immediately report, to the facility's administrator, 1 of 3 injuries of</p>		W0153	See tag # 149, p. 2		11/07/2011	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>unknown origin which involved 1 of 2 sampled clients living at the group home (client #1) in accordance with state law.</p> <p>Findings include:</p> <p>The facility's incident reports, abuse/neglect allegations, and investigations, from 10/1/10 to 10/3/11, were reviewed on 10/3/11 at 2:06 P.M.. The review indicated the following injury of unknown origin involving client #1: "Name: [Client #1], Incident Date: 05/27/2011, Date of knowledge: 05/31/2011, Narrative: While assisting [client #1] with a bath, staff noticed a bruise on [client #1's] left hip. Staff asked [client #1] how he got the bruise and he (client #1) stated that he did not know. Plan to Resolve: Staff filled out a (sic) incident report and sent it in the mail to the Community Services Nurse (Nurse #3.) Due to the holiday weekend and the fact that the staff is new, we (Service Coordinator #1 and Nurse #3) did not receive the report until 5/21/11. An internal investigation has been started to determine the origin of the bruise, will follow up with the results upon completion."</p> <p>Service Coordinator #1 was interviewed on 10/4/11 at 11:52 A.M.. Service Coordinator #1 indicated the bruise to</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0154	<p>client #1's hip was discovered by staff on 5/27/11 and the facility's administrator was not notified of the injury to client #1 until 5/31/11. 9-3-2(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 1 investigation records, involving 4 of 5 clients (clients #1, #2, #3 and #4) the facility failed to investigate an allegation of financial exploitation timely.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/4/11 at 10:40 A.M.. Review of the facility's investigation record indicated internal incident/accident reports and Bureau of Developmental Disabilities Services (BDDS) reports which indicated the following:</p> <p>1. Incident/Accident report dated 4/9/11 and 4/11/11, date of referral 6/30/11: "Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of</p>		W0154	<p>Allegations of financial exploitation will be turned into the Quality Assurance Director within 24 hours of notification for investigation.</p> <p>To ensure future compliance, all incident reports will be reviewed as received.</p> <p>See attached procedures.</p>		11/07/2011	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>the report failed to indicate the amount of money withdrawn.</p> <p>2. Incident/Accident report dated 4/11/11 and 3/23/11: "Someone has made withdrawal out of [client #2]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>3. Incident/Accident report dated 4/11/11 and 5/23/11: "Someone has made withdrawals out of [client #3]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Incident/Accident report dated 4/11/11: "Someone has made withdrawals out of [client #4]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>5. BDDS report dated 7/19/11: "Staff</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>notified Service Coordinator that when she went to the bank with a client (client #1) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>6. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #2) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>7. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #3) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>8. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #4) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>Further review of the investigation record indicated:</p> <p>1. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15539...[Client #4]...Date: 6/30/11...Someone has made withdrawals out of [client #4] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>2. Staff/Client Incident Report Summary Sheet: "Incident Report Number:</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>15538...[Client #1]...Date: 6/30/11...Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>3. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15540...[Client #3]...Date: 6/30/11...Someone has made withdrawals out of his account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15541...[Client #2]...Date: 6/30/11...Someone has made withdrawals out of [client #2] savings account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>An interview with the Service Coordinator (SC) was conducted on 10/4/11 at 12:20 P.M.. The SC indicated the reporting staff reported the incidents to her on 6/30/11 but she had to wait for the bank statements to come to verify the withdrawals before conducting an investigation.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0156	<p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 1 of 1 investigation records, involving 4 of 5 clients (clients #1, #2, #3 and #4), the facility failed to report the results of the investigation to the administrator within five working days of the incident.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/4/11 at 10:40 A.M.. Review of the facility's investigation record indicated internal incident/accident reports and Bureau of Developmental Disabilities Services (BDDS) reports which indicated the following:</p> <p>1. Incident/Accident report dated 4/9/11 and 4/11/11, date of referral 6/30/11: "Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of</p>			W0156	See tag 104, p. 2		11/07/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>the report failed to indicate the amount of money withdrawn.</p> <p>2. Incident/Accident report dated 4/11/11 and 3/23/11: "Someone has made withdrawal out of [client #2]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>3. Incident/Accident report dated 4/11/11 and 5/23/11: "Someone has made withdrawals out of [client #3]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Incident/Accident report dated 4/11/11: "Someone has made withdrawals out of [client #4]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>5. BDDS report dated 7/19/11: "Staff</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>notified Service Coordinator that when she went to the bank with a client (client #1) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>6. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #2) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>7. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #3) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>8. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #4) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation."</p> <p>Further review of the investigation record indicated:</p> <p>1. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15539...[Client #4]...Date: 6/30/11...Someone has made withdrawals out of [client #4] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>2. Staff/Client Incident Report Summary Sheet: "Incident Report Number:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>15538...[Client #1]...Date: 6/30/11...Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>3. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15540...[Client #3]...Date: 6/30/11...Someone has made withdrawals out of his account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15541...[Client #2]...Date: 6/30/11...Someone has made withdrawals out of [client #2] savings account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>An interview with the Service Coordinator (SC) was conducted on 10/4/11 at 12:20 P.M.. The SC indicated the reporting staff reported the incidents to her on 6/30/11 but she had to wait for the bank statements to come to verify the withdrawals before conducting an investigation. The SC further indicated the facility's administrator was not notified of investigative finding within five working days of the incident.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0157	<p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed for 4 of 5 clients residing in the group home (clients #1, #2, #3 and #4) to take effective corrective action for reported allegations of financial exploitation.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/4/11 at 10:40 A.M.. Review of the facility's investigation record indicated internal incident/accident reports and Bureau of Developmental Disabilities Services (BDDS) reports which indicated the following:</p> <p>1. Incident/Accident report dated 4/9/11 and 4/11/11, date of referral 6/30/11: "Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Review of the report failed to indicate the amount of</p>		W0157	<p>See W 154 & W 9999 See tag 104</p>		11/07/2011	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>money withdrawn. No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>2. Incident/Accident report dated 4/11/11 and 3/23/11: "Someone has made withdrawal out of [client #2]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Review of the report failed to indicate the amount of money withdrawn. No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>3. Incident/Accident report dated 4/11/11 and 5/23/11: "Someone has made withdrawals out of [client #3]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Review of the report failed to indicate the amount of money withdrawn. No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>4. Incident/Accident report dated 4/11/11: "Someone has made withdrawals out of [client #4]'s savings</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Review of the report failed to indicate the amount of money withdrawn. No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>5. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #1) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation." No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>6. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #2) that there seemed to be money missing from his account...Service Coordinator started gathering information</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation." No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>7. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #3) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation." No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>8. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #4) that there seemed to be money</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation." No documentation was available for review to indicate the facility took effective corrective action after this incident.</p> <p>Further review of the investigation record indicated:</p> <p>1. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15539...[Client #4]...Date: 6/30/11...Someone has made withdrawals out of [client #4] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>2. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15538...[Client #1]...Date: 6/30/11...Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1] account." Further review of the report failed to indicate the amount of money withdrawn.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>3. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15540...[Client #3]...Date: 6/30/11...Someone has made withdrawals out of his account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15541...[Client #2]...Date: 6/30/11...Someone has made withdrawals out of [client #2] savings account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>Review of the SC notes dated 7/17/11 indicated: "No deposit slips for 4/11/11 or 5/23/11 for all gentleman...Budgets were available-(not done)...\$35.00 x 3 missing and \$50.00 x 4 missing." Further review failed to indicate what amount belonged to each client.</p> <p>A review of the clients' personal financial records dated 6/24/11 to 9/30/11 was conducted on 10/4/11 at 11:50 A.M.. Review of client #1's record failed to indicated a cash reimbursement from the facility for missing funds. Review of client #2's record failed to indicate a cash reimbursement from the facility for missing funds. Review of client #3's record failed to indicate a cash</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0331	<p>reimbursement from the facility for missing funds. Review of client #4's record failed to indicate a cash reimbursement from the facility for missing funds.</p> <p>An interview with the Service Coordinator (SC) was conducted on 10/4/11 at 12:20 P.M.. The SC indicated there was no documentation available for review to indicate the facility took effective corrective action.</p> <p>9-3-2(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 5 clients residing at the group home (client #4), the facility failed to provide nursing services for the client's injury.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 10/3/11 from 5:00 P.M. until 8:30 P.M.. Upon client #4's arrival to the group home at 5:30 P.M.,</p>			W0331	<p>By this incident not being an emergency, the group home staff left a message with their team nurse, which the nurse returned their call later that evening. Staff did not call the nurse emergency cell phone due to the situation was non-emergency. Client was seen by the podiatrist the same day. To ensure future compliance, the group home staff will be re-trained on the protocol for calling the nurse. A memo will also be sent to all of residential group homes to prevent further occurrence.</p>		11/07/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Direct Support Professional (DSP) #2 was observed to escort client #4 into his bedroom. At 6:30 P.M., DSP #2 indicated client #4's sock was soaked with blood from a prior injury he acquired by stubbing his toe. DSP #2 further indicated she called the group home Licensed Practical Nurse (LPN) and left a message and was awaiting a call back for instruction. LPN staff did not return the call by 8:30 P.M..</p> <p>A review of the facility's "When to Call a Nurse" procedure no date noted was conducted on 10/4/11 at 12:50 P.M.. review of the procedure indicated: "The Nurse assigned to the group home is to be contacted regarding any changes in a client's medical condition. If no answer, leave a message and wait 30 minutes for a return call; call the nurse's emergency phone...When calling a Nurse, there is a 30 minute response time."</p> <p>An interview with the Director of Nursing (DON) was conducted on 10/4/11 at 1:00 P.M.. The DON indicated nursing staff should respond within 30 minutes when DSP staff contact them about medical concerns in regards to clients. When asked if client #4 had been assessed by the group home LPN, she indicated the group home LPN had not assessed client #4's injury but would do so after lunch. No</p>				<p>11/10/11 All DSPs are trained on cores A&B of the Living in the Community Medical aspect of foundations. During this training all staff is trained on assessing and treating minor medical issues such as scratches, bruises, etc., and the difference identifying an emergency medical need. In this case, the client had a podiatrist appointment on the same day, which when he got home the band aid was bloody; and they were calling to notify the nurse they had changed the band aid. Therefore, the staff followed trained procedures in contacting the nurse. Since the issue was non emergency call procedure. The Nurse correctly followed the call back procedure by returning the call. If this had been an actual emergency, the group home staff would have called the emergency nurse's cell phone, and the nurse would be expected to return the call within 30 minutes. In addition, nurses and the group home staff has been retrained on the call procedure to ensure a more timely response by a licensed medical professional.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W9999	<p>further documentation was available for review to indicate the group home LPN responded to the group home call or assessed client #4's injury.</p> <p>9-3-6(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(b)</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidence by:</p> <p>Based on record review and interview, the facility failed for 1 of 1 investigation record of an allegation of financial exploitation reviewed involving 4 of 5 clients residing at the group home (clients #1, #2, #3 and #4), to report Bureau of Developmental Disabilities Services (BDDS) follow up reports in a timely manner..</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 10/4/11 at 10:40 A.M.. Review of the facility's investigation record indicated internal</p>			W9999	<p>Service Coordinator will be re-trained by the Quality Assurance Director to turn in follow up reports within 7 days.</p> <p>To ensure future compliance, Quality Assurance Director will monitor Bdds's follow up reports.</p>		11/07/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>incident/accident reports and Bureau of Developmental Disabilities Services (BDDS) reports which indicated the following:</p> <p>1. Incident/Accident report dated 4/9/11 and 4/11/11, date of referral 6/30/11: "Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Review of the report failed to indicate the amount of money withdrawn.</p> <p>2. Incident/Accident report dated 4/11/11 and 3/23/11: "Someone has made withdrawal out of [client #2]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Review of the report failed to indicate the amount of money withdrawn.</p> <p>3. Incident/Accident report dated 4/11/11 and 5/23/11: "Someone has made withdrawals out of [client #3]'s account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Incident/Accident report dated 4/11/11: "Someone has made withdrawals out of [client #4]'s savings account...Report to Service Coordinator (SC)...To (sic) many people have access to the clients money. There is no separation of duties." Review of the report failed to indicate the amount of money withdrawn.</p> <p>5. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #1) that there seemed to</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation." No documentation was available for review to indicate the facility submitted a follow-up report.</p> <p>6. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #2) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation." No documentation was available for review to indicate the facility submitted a follow-up report.</p> <p>7. BDDS report dated 7/19/11: "Staff notified Service Coordinator that when she went to the bank with a client (client #3) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation." No documentation was available for review to indicate the facility submitted a follow-up report.</p> <p>8. BDDS report dated 7/19/11: "Staff notified</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Service Coordinator that when she went to the bank with a client (client #4) that there seemed to be money missing from his account...Service Coordinator started gathering information to account: 7/12/11 received bank statement in office: 7/17/11 conducted internal investigation and found monies to be missing after visiting group home; 7/18/11 received other deposit withdraws in the inner-office mail. 7/19/11 requested formal internal investigation." No documentation was available for review to indicate the facility submitted a follow-up report.</p> <p>Further review of the investigation record indicated:</p> <p>1. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15539...[Client #4]...Date: 6/30/11...Someone has made withdrawals out of [client #4] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>2. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15538...[Client #1]...Date: 6/30/11...Someone has made withdrawal on 4/9/11 or 4/11/11 out of [client #1] account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>3. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15540...[Client #3]...Date: 6/30/11...Someone has made withdrawals out of his account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>4. Staff/Client Incident Report Summary Sheet: "Incident Report Number: 15541...[Client #2]...Date: 6/30/11...Someone has made</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>withdrawals out of [client #2] savings account." Further review of the report failed to indicate the amount of money withdrawn.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 10/4/11 at 5:00 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS...Incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to:</p> <p>3. Alleged, suspected or actual exploitation (which must also be reported to Adult Protective Services or Child Protective Services as indicated) which includes but is not limited to:</p> <p>a. unauthorized use of the:</p> <p>i. personal services;</p> <p>ii. personal property or finances; or</p> <p>iii. personal identity of an individual;</p> <p>b. other instance of exploitation of an individual for one 's own profit or advantage or for the profit or advantage of another.</p> <p>Responsible Parties</p> <p>1. The provider responsible for an individual at the time of the occurrence of a reportable incident shall submit an incident initial report.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G475		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2011	
NAME OF PROVIDER OR SUPPLIER ARC BRIDGES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5777 ELLSWORTH CT MERRILLVILLE, IN46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Initial incident reporting to BQIS</p> <p>1. Within 24 hours of initial discovery of a reportable incident, the reporting person shall file an incident initial report with BQIS using the DDRS approved electronic format available at https://ddrsprovider.fssa.in.gov/IFUR/.</p> <p>Reportable Incident Follow-Up</p> <p>3. The person responsible for incident follow-up reporting shall:</p> <p>a. submit an electronic incident follow-up report within 7 days of the date of the incident initial report;</p> <p>b. continue to submit incident follow-up reports on an every 7 day schedule, until such time as the incident is resolved to the satisfaction of all entities;</p> <p>An interview with the Service Coordinator (SC) was conducted on 10/4/11 at 12:20 P.M.. The SC indicate no follow up reports were submitted. No further documentation was available for review to indicate follow up reports were submitted timely to BDDS.</p> <p>9-3-1(b)</p>						